AUTHORIZATION FOR DISCLOSURE OF MEDICAL AND/OR EDUCATIONAL INFORMATION

Name of student (list other names used)	*Medical Record Number (if applicable)*	*Date of Birth*
Address of student	*Home Phone No.*	*Other/Cell Phone No.*

I, _____, authorize the _____ to:
[name of Student/Student's Rep] [Name of Educational Agency]

☐ Release the above-named individual's *medical*/educational information as identified below to:

Individual or Organization Receiving Information

_____
Receiving Party

_____
Address

_____
City, State, Zip Code

_____
Telephone/Fax

☐ Obtain the above-named individual's *medical*/educational information as identified below from:

Individual or Organization Disclosing Information

_____
Disclosing Party

_____
Address

_____
City, State, Zip Code

_____
Telephone/Fax

Duration: This authorization shall become effective immediately and shall remain in effect until for one year from the date of signature.

Revocation: I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the *disclosing* agency. Written revocation will be effective upon receipt, but will not apply to information that has already been released in response to this authorization.

Redisclosure: I understand that medical/educational information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and it *may* no longer protected by federal laws and regulations regarding the privacy of protected health information. I further understand the confidentiality of the information when released to a public educational agency is protected as a student record under the Family Educational Rights and Privacy Act (FERPA) and the recipient may not redisclose the information without parental consent

Health Info: I understand that authorizing the disclosure of health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form in order to assure medical treatment.

Specify Record(s): Indicate type of information that is to be disclosed.

☐ Medical Information ☐ Medication Information ☐ Psychological/Psychiatric Information ☐ Mental Health

☐ Drug/Alcohol Information ☐ Educational Records ☐ Other:_____

I request that the information released pursuant to this authorization be used for the following purposes only:

☐ Educational Assessment ☐ Educational Planning/IEP development ☐ Other:_____

A copy *or facsimile* of this authorization is as valid as an original. I understand that I have a right to receive a copy of this authorization for my *or my child/ward's* records. *I understand that I may request to inspect or obtain a copy of the information to be used or disclosed.*

Signature of Student or Student's Representative	*Description of Relationship to Student*	*Date*

This authorization is in compliance with the terms of the Family Education Rights and Privacy Act and the Confidentiality of Medical Information Act of 1981, Section 56, et. seq., California Civil Code.